Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-8287-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider did not request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to Section 134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $10,391.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider filed a request for medical dispute resolution for out-patient surgery performed on May 20, 2008. The provider billed $42,076.37. The provider was reimbursed the sum of $20,034.33. The provider is seeking an additional $10,391.97. The carrier processed the medical bill on June 13, 2008. The carrier's position remains consistent with its EOB."

Response Submitted by: Zurich c/o Flahive, Ogden & Latson; 504 Lavaca, Suite 1000; Austin TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2008	Outpatient Surgery	$10,391.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. This request for medical fee dispute resolution was received by the Division on May 18, 2009.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16/253 – claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate; in order to review this charge we will need a copy of the invoice.
   - 97/226/284 – payment is included in the allowance for another service/procedure; included in global charge/no allowance was recommended as this procedure has a Medicare status of "B" (bundled)
   - W1/790/370 – workers compensation state fee schedule adjustment; this charge was reimbursed in accordance to the Texas medical fee guideline; this hospital outpatient allowance was calculated according to the APC rate plus a markup

Findings

1. Because no contract exists, reimbursement for the services in dispute is established under 28 Texas Administrative Code §134.403(f) which states, "The reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register.* The following minimal modifications shall be applied…" Therefore, the Division must first determine the Medicare OPPS payment and then apply the minimal modifications required by §134.403(f) in order to establish the MAR.
2. Under the Medicare OPPS, all services paid under OPPS are classified into groups called Ambulatory Payment Classifications or APCs. APCs are based on the services that appear on the hospital bill, the codes used, and the supporting documentation. A payment rate is established for each APC. A full list of APCs is published in the OPPS final rules each year which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website.
3. 28 Texas Admin Code §134.403(d) requires that for coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided. Effective January 1, 2007, the language in the *Medicare Claims Processing Manual,* Publication 100-04, Chapter 4, 61.3.2, was revised to reflect changes in device edits for outpatient hospital services provided under the Medicare OPPS. The "Procedure to Device" edits change requires that when a particular procedural HCPCS code is billed, the hospital bill must also contain an appropriate device code. This January 2007 update was introduced in Medicare Learning Network (MLN) publication titled MLN Matters Number MM5438 found on the CMS website. The procedure to device edits is updated annually and is also found on the CMS website.
4. This dispute relates to outpatient hospital services provided in calendar year 2008. Review of the documentation finds that procedure code 63685 is among the services billed. Review of the procedure to device edits for 2008 finds that procedure code 63685 requires a corresponding, valid device code. No documentation was found to support that the required device codes appeared on the hospital bill along with procedure code 63685. Medicare states that if a hospital bill fails to pass the procedure to device code edit, the hospital bill would be returned to the submitter and would not be processed. For this reason, an OPPS payment amount cannot be established for the services in dispute. Consequently, the MAR cannot be established.

Conclusion

For the reasons stated above, the Division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September , 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.